DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITALS)

SUBJECT: **BED AVAILABILITY REPORT** REFERENCE NO. 1122.1

Hospital Name: _____

		# Available Immediately	# Available within 24 Hours	# Available within 72 Hours
			Complete only when checked ☐	Complete only when checked ☐
1	Medical/Surgical			
2	Adult ICU			
3	Telemetry			
4	Pediatric ward			
5	Pediatric ICU			
6	Operating Room			
7	Negative pressure/Isolation			
8	Neonatal ICU			
9	Trauma			
10	Burn			
11	Obstetric/Gynecology			
12	Psychiatric			
13	Other (please define)			
14				
15	Ventilators			
16	ED Diversion Status	Open or Sat		
17	Mass decontamination facility available	Yes or No		
18				

Report completed by: _____ _____ _____
NAME PHONE DATE

FAX COMPLETED FORM TO (562) 906-4300 WITHIN 60 MINUTES OF REQUEST